Send to: Family Life Insurance Company
P.O. Box 924408
Houston, TX 77292-4408

PART II

STATEMENT MADE TO MEDICAL EXAMINER

FAMILY LIFE INSURANCE COMPANY

	Yes	No
1. Have you had a physical check-up or health examination within the past three years?	☐	☐
or If "YES" complete the following:		
Did any symptoms prompt this examination?	☐	☐
Was any prescription or advice received?	☐	☐
Give details below, including doctor's name, address and date of latest examination.		

2. Height ____ Ft. ____ In. Weight ____ lbs.

3. Family record	Age if living	Age at death	Cause of death or current health status
Father			
Mother			
Brothers ____			
Sisters ____			

4. When and for what purpose did you last consult a doctor or other medical practitioner?

Name and address ____

5. Have you ever had or been told you had: (IF "YES" ENCIRCLE ITEM AND GIVE DETAILS–IDENTIFY BY QUESTION NUMBER AND LETTER)
For conditions marked with (*) please submit home office specimen.

	Yes	No	Doctor's name and address, dates, number of attacks, duration, etc.
a. Rheumatic fever, heart murmur, heart disease or disorder, chest pain, high blood pressure*, anemia or other disorder of the blood or circulatory system?	☐	☐	
b. Paralysis*, dizziness, chronic headaches or any allergy?	☐	☐	
c. Kidney disease*, blood in urine*, stones or gravel*, syphilis*, prostate* or other genito-urinary disorder*?	☐	☐	
d. Diabetes*, sugar in urine*, thyroid disorder, arthritis, gout*, cancer, tumor or skin growth?	☐	☐	
e. Asthma, pleurisy*, bronchitis, tuberculosis* or emphysema?	☐	☐	
f. Gall bladder, liver, digestive or bowel disorder, ulcer or hernia?	☐	☐	
g. Convulsion, epilepsy, stroke, loss of consciousness, nervous breakdown, emotional illness, eye disease or disorder of the ear, brain or nervous system?	☐	☐	
h. Bone, joint or spinal disorder, back or neck pain?	☐	☐	
i. AIDS or evidence of any immune system deficiency?	☐	☐	
6. Have you ever been hospitalized for any reason?	☐	☐	
7. Have you ever had consultation, medical advice, treatment or hospitalization concerning your use of alcohol or drugs or have you ever used drugs habitually?	☐	☐	
8. Any weight loss in past year? If yes, state number of pounds and how and why lost.	☐	☐	
9. Within the past five years, have you had or been told you had:	Yes	No	
a. An electrocardiogram (EKG), X ray, or blood study?	☐	☐	
b. Any other consultations with doctors or other medical practitioners for any other physical or mental impairment, illness, injury or operation not otherwise listed? If "YES," give details, including dates, names and addresses, etc.	☐	☐	
10. a. If female: Have you ever had or been told you had any breast disorder, disease of the female organs or hysterectomy?	☐	☐	
b. Is applicant pregnant? State month ____	☐	☐	

I have read the foregoing and represent that my above answers are COMPLETE and TRUE to the best of my knowledge and belief and agree that they shall constitute a part of this application. I further agree that if required by the Company as a condition to the completion of this application, I will without delay furnish to the Company any other evidence of insurability it may reasonably require. I understand and agree that no information acquired by any representative of the Company shall bind the Company unless such information is stated in this application and that no agreement, waiver or modification of the application or the policy, if and when issued, shall bind the Company unless stated in writing and signed by an officer of the Company.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person having any records or knowledge of me or my health, to communicate to Family Life Insurance Company or its reinsurers any such information, and I expressly waive all privileges relating to such communications to the extent permitted by law. Photostatic copy of this authorization shall be as valid as the original.

Signed this ____ day of ____, 19 ____

Witness ____ Signed ____

(MEDICAL EXAMINER) (PROPOSED INSURED)

A-304-883

PART III **FAMILY LIFE INSURANCE COMPANY**

Administrative office
P.O. Box 924408
Houston, TX 77292-4408

Please DO NOT Make Any Comments to the Applicant Regarding Your Interpretation of His Insurability

1. Name of Applicant _____

Address _____ City _____

Sex: M ____ F ____ Birth Month ____ Day ____ Year ____

2. CARDIOVASCULAR EXAMINATION
A. Blood Pressure (All readings to be taken in sitting position. If first reading over 140/90 make two additional observations at intervals. Send urine specimen to Home Office in all cases of blood pressure elevation.)

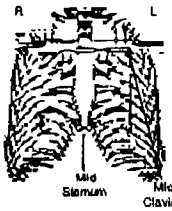
	Systolic	Diastolic (fifth phase)
1st reading		
2nd reading		
3rd reading		

B. PULSE RATE (Do Not Exercise if Contraindicated).

Effort must result in pulse rate of at least 100	Before exercise	Immediately after	3 minutes after
Pulse rate			
No. irregularities of pulse/minute			

C. HEART EXAMINATION (Space for additional details below).

1. Degree of hypertrophy: ☐ None ☐ Slight ☐ Moderate ☐ Marked
2. Any evidence of decompensation? YES ☐ NO ☐
3. Is there a murmur? YES ☐ NO ☐
If "YES" furnish the following information: ♦
a. Location: ☐ Mitral ☐ Aortic ☐ Pulmonic
b. Timing: ☐ Systolic ☐ Presystolic ☐ Diastolic
c. Intensity: ☐ Faint ☐ Moderate ☐ Loud
d. Quality: ☐ Soft ☐ Blowing ☐ Rough
e. How is murmur affected by: Respiration? _____
Exercise? _____ Recumbency? _____
f. Is murmur transmitted? YES ☐ NO ☐ Where? _____
g. What is your diagnosis of the lesion? _____
4. Is there a thrill? YES ☐ NO ☐
5. LOCATE ON CHART
Apex by
Area of murmur by
Point of greatest intensity by
Transmission direction by



3. A. Does Applicant smoke cigarettes? YES ☐ NO ☐
B. Does Applicant use tobacco products in any form? YES ☐ NO ☐

4. Measurements: Height ____ ft. ____ in. Weight ____ lbs.
Did you measure? YES ☐ NO ☐ Did you weigh? YES ☐ NO ☐
Chest: full inspiration _____ in., forced expiration _____ in.
Abdomen: at umbilicus ____ in.

5. HERNIA
Is There a Hernia? YES ☐ NO ☐ Reducible? YES ☐ NO ☐
Type of Hernia? _____

IF ANSWERS TO ANY OF QUESTIONS 5 & 6 ARE "YES" GIVE FULL DETAILS BELOW:

6. Do you find any abnormalities or evidence of past or present disease of:	YES	NO
A. Brain or Nervous System? (Test reflexes, knee jerks, pupils and Romberg Test.)	☐	☐
B. Lungs or other parts of the Respiratory System?	☐	☐
C. Stomach or other Abdominal Organs? (Give details regarding any enlargement, tenderness, etc. of the spleen or liver.)	☐	☐
D. Genito-Urinary System?	☐	☐
E. Ears, Eyes, Nose or Throat? (If person is deaf, indicate if hearing aid if worn or speech is affected.)	☐	☐
F. Endocrine System? (Give details regarding any thyroid enlargement, e.g. type, size and extent. If hyperthyroidism is involved give details as to effect on other systems.)	☐	☐
G. Bones, Joints, Glands or Skin?	☐	☐
H. Any other part of the body?	☐	☐

	YES	NO
7. Is there any paralysis, deformity, lameness or loss of limb?	☐	☐

8. URINALYSIS (If there is any abnormality of the urine, history of urinary impairment within the last year or if applicant is over age 50, send portion of original specimen to Home Office).

	YES	NO
Are you satisfied the specimen is authentic?	☐	☐

Specific gravity _____ Albumin _____ Sugar _____

ARE YOU SENDING A SPECIMEN TO HOME OFFICE?	☐	☐

9. Blood Study–If you have been requested to have Applicant submit a blood sample, please draw venous blood and carefully read blood kit instructions. If any questions, please call Osborn Laboratory (913) 764-5555

	YES	NO
ARE YOU SENDING A BLOOD SAMPLE?	☐	☐

Space for Details and Remarks–Identify by Question Number

I certify that I have carefully examined the above Applicant, in private, and not in the presence of any other person except as stated in the space above, that I have asked each question exactly as set forth on Part II of this form and that the answers thereto are in my handwriting and are exactly as made to me, and that they have been signed in my presence.
Examined at: ☐ APPLICANT'S RESIDENCE, ☐ MY OFFICE or ☐ OTHER (explain above) on _____ at ____ o'clock (a.m.) (p.m.)
MONTH DAY YEAR

_____ M.D.

Examination authorized by:

_____
STREET OR P.O. BOX

_____ _____ _____
AGENT CITY STATE

A-16 PIII 288

Mail Direct to Family Life Insurance Company in Envelope Provided

EXAMINATION FEE PAYMENT VOUCHER

Please Write Legibly

_____
PROPOSED INSURED'S NAME

_____
Medical Examiner's Name–Affiliated with

_____
STREET OR P.O. ADDRESS

_____ _____ _____
CITY STATE ZIP

☐ Physician's Exam
☐ Paramedical Exam
☐ Other _____ $ _____

_____
SOCIAL SECURITY OR TAX NUMBER

A-16v

Family Life Insurance Company

P.O. Box 924408 • Houston, Texas 77292-4408 • (800) 877-7705

NOTICE AND CONSENT FOR HIV-RELATED TESTING

To evaluate your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

PRE-TESTING CONSIDERATIONS

Many public health organizations have recommended that before taking an HIV-related test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

MEANING OF POSITIVE TEST RESULT

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

NOTIFICATION OF TEST RESULT

If your test result are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting
a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

CONSENT

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the collection of a sample of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signature of Proposed
Insured or Parent/Guardian _____ Date Signed: _____

Name of Proposed Insured: _____ Address: _____

THIS NOTICE AND CONSENT IS REQUIRED BY THE TEXAS STATE BOARD OF INSURANCE

CONSENT FORM MUST BE EXECUTED IN TRIPLICATE:
Please send original to Administrative Office • 1 copy to client • 1 copy to examiner